STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155269	A. BUILDING _____ B. WING _____	C 12/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE NURSING & REHABILITATION CENTER	**1900 JEANWOOD DR ELKHART, IN 46514**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00184825. Complaint IN00184825 - Substantiated. No deficiencies related to the allegations are cited. Survey date: December 10, 2015. Facility number: 000169 Provider number: 155269 AIM number: 100267100 Census bed type: SNF: 14 SNF/NF: 123 Total: 137 Census payor type: Medicare: 25 Medicaid: 99 Other: 13 Total: 137 Sample: 3 East Lake Nursing & Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaint IN00184825. Quality Review completed by 14454 on December 14, 2015.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE